REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: 1) [redacted], Group Chief Executive Officer, Manchester University NHS Foundation Trust; and 2) [redacted], Chief Executive, National Institute for Health and Care Excellence

CORONER

I am Chris Morris, Area Coroner for Manchester South.

CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 1ST November 2023, Lauren Costello, Assistant Coroner for Manchester South, opened an inquest into the death of Thomas Gibson who was found to have died at his home on 7th June 2023, aged 40 years. The investigation concluded with an inquest which I heard on 4th and 5th June 2024.

The inquest determined Mr Gibson died as a consequence of:

1) a) Sudden cardiac death;

1)b) Idiopathic myocardial fibrosis.

II) Acute on chronic colitis

At the end of the inquest, I recorded the following Narrative Conclusion:

Mr Gibson died at his home as a consequence of sudden cardiac death due to myocardial fibrosis. Eleven days previously, Mr Gibson had been seen at his local hospital which provides specialist cardiac services, where the clinical team assessing him did not appreciate that ECGs showed him to be experiencing complete heart block. Had this been appreciated, Mr Gibson would have been admitted under the care of the cardiologists and a series of investigations undertaken which would probably have culminated in an implantable device such as a pacemaker being fitted. It is likely these measures would have avoided his death.

CIRCUMSTANCES OF THE DEATH

Mr Gibson was found dead at home on 7th June 2023. A post mortem examination determined the primary cause of his death arose from idiopathic myocardial fibrosis which had not been diagnosed during his lifetime. Mr Gibson was not known to have any chronic health problems.

During May 2023, Mr Gibson developed a gastrointestinal illness for which he initially sought medical attention via his local GP Surgery. As his symptoms did not improve, a call was made to NHS 111 which resulted in Mr Gibson being advised to attend the Emergency Department at Wythenshawe Hospital. There, a series of initial tests were undertaken, including an ECG. The ECG

machine self-generated a report indicating that the ECG was abnormal, showing features of Long QT syndrome. Having reviewed this ECG, a junior doctor initiated treatment for Long QT syndrome, and referred Mr Gibson to the medical team.

A junior doctor in medicine reviewed Mr Gibson later in the day, by which stage lab results from a stool sample taken in the community had been reported as showing the presence of Campylobacter. A repeat ECG was undertaken. This again came with a self-generated report indicating the ECG was abnormal, but the junior doctor considered it to show a heart in normal sinus rhythm. The ECG was discussed in isolation with the Medical Registrar who, whilst recognising the ECG was abnormal, did not consider any immediate additional action was indicated.

Mr Gibson was discharged from hospital. The discharge letter which was sent to his GP makes no mention of the ECGs undertaken, or the fact that Mr Gibson had received treatment in the Emergency Department in response to an ECG abnormality.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

To the Group Chief Executive Officer, Manchester University NHS Foundation Trust

1. Whilst some important learning has been derived from the Trust's review of the care provided to Mr Gibson, I am concerned that a narrow focus on the error of three different doctors to interpret two ECGs correctly (rather than any broader consideration of the context in which such misinterpretations occurred) represents a missed opportunity to fully understand the factors that led to Mr Gibson's discharge from hospital, thus creating a risk of future deaths.

2. Having carefully considered all of the evidence at inquest, I am concerned that there does not appear to be clear guidance available to those working within the Trust as to what is required when communicating (particularly as to test results and a patient's presentation) as between different specialisms and as between different roles within the team.

3. Connected with the above, I am concerned that the court heard evidence to the effect there is no specific guidance as to expected minimum standards as to obtaining appropriate context / information for clinicians (whether from the HIVE system or otherwise) when asked to review a single test or investigation result in isolation.

4. I am also concerned that there does not currently appear to be any particular requirement in place for a senior review of the patient to take place in circumstances where diagnostic tests undertaken yield results which appear incongruous / unexpected in the context of their presentation.

5. Given the Trust's own findings on investigation, I am concerned that no wider audit of ECGs interpreted in the Emergency Department / Acute Medical Unit prior to discharge of patients appears to have been undertaken; and

6. It is a matter of concern that no audit as to the sufficiency of detail contained in discharge summaries appears to have been undertaken to date in the light of the issues identified by the Trust's High Impact Learning Assessment.

To the Chief Executive, National Institute for Health and Care Excellence

1. The court heard evidence that ECGs are used by different professional groups in a wide range of clinical settings. A consultant cardiologist in this case gave evidence that complete heart block was sometimes a wholly incidental finding on ECG, with the patient not previously exhibiting any obvious signs or symptoms. In the present case, the court heard evidence that the computer-generated interpretations of two EGCs were both incorrect, and that three different (relatively experienced) doctors misinterpreted the ECGs. In those circumstances, I am concerned there are currently no authoritative national guidelines (such as those which exist for CTGs) in place as to the use and interpretation of ECGs in various clinical settings.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **14th August 2024**. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and Mr Gibson's partner. I have also sent a copy to the General Practitioner.

I have also sent a copy to the Care Quality Commission and NHS Greater Manchester Integrated Care Partnership who may find it useful or of interest.

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

Dated: **19th June 2024**

Signature: Chris Morris HM Area Coroner, Manchester South.